

13. MEDICARE

Table 13-1. Federal Resources in Support of Medicare

(In millions of dollars)

Function 570	2000 Actual	Estimate					
		2001	2002	2003	2004	2005	2006
Spending:							
Discretionary Budget Authority ...	2,998	3,352	3,466	3,549	3,631	3,714	3,800
Mandatory Outlays:							
Existing law	194,115	216,002	226,448	238,575	252,231	270,784	279,426
Proposed legislation	8,300	12,800

Created by the Social Security Amendments of 1965, and expanded in 1972, Medicare is a nationwide health insurance program for the elderly and certain people with disabilities. The program will spend an estimated \$226 billion in 2002 on mandatory benefits (net of beneficiary premiums) and administrative costs.

Medicare was designed to address a serious, national problem in health care—the elderly often could not afford to buy health insurance, which was more expensive for them than for other Americans because they had higher health care costs. Medicare was expanded in 1972 to address a similar problem of access to insurance for people with disabilities. Through Medicare, the Federal Government created one insurance pool for all of the elderly and eligible disabled individuals while subsidizing some of the costs, thus making insurance much more affordable for almost all elderly Americans and for certain people with disabilities. Medicare expanded access to quality care for the elderly and people with disabilities. With rapid changes in the health care industry, however, Medicare’s approach to health care coverage has become increasingly dated. Medicare’s benefits have significant gaps, including the lack of a prescription drug benefit. Medicare provides fewer coverage options for many beneficiaries than are enjoyed by employees of large private firms and the Federal Government. As a result, many beneficiaries do not have access

to innovative disease management programs for their chronic illnesses, or to coverage options that would help them limit their out-of-pocket costs. In addition, Medicare has an enormous and growing long-term financing gap.

Medicare Benefits

In contrast to the integrated health insurance plans that provide coverage for most non-elderly Americans today, Medicare’s structure continues to reflect the historical division of health insurance into a “hospital” component and a “physician” component that existed at the time the program was created. Medicare has two parts: (1) Hospital Insurance (Part A) and (2) Supplementary Medical Insurance (Part B).

Part A covers almost all Americans age 65 or older, and most persons who are disabled for 24 months or more and who are entitled to Social Security or Railroad Retirement benefits. People with end-stage renal disease (ESRD) also are eligible for Part A coverage. Part A reimburses providers for the inpatient hospital, skilled nursing facility, home health care related to a hospital stay, and hospice services provided to beneficiaries. Part A’s Hospital Insurance (HI) Trust Fund receives most of its income from the HI payroll tax—2.9 percent of payroll, split evenly between employers and employees.

Part B coverage is optional, and it is available to almost all resident citizens age 65 or older and to people with disabilities who are entitled to Part A. About 94 percent of those enrolled in Part A have chosen to enroll in Part B. Enrollees pay monthly premiums that cover about 25 percent of Part B costs, while general taxpayer dollars subsidize the remaining costs. For most beneficiaries, the Government simply deducts the Part B premium from their monthly Social Security checks. Part B pays for medically necessary physician services; outpatient hospital services; diagnostic clinical laboratory tests; certain durable medical equipment (e.g., wheelchairs) and medical supplies; home health care; physical and occupational therapy; speech pathology services; and outpatient mental health services. Part B also covers kidney dialysis and other services for ESRD patients.

Public vs. Private Health Care Coverage

Beneficiaries can choose the coverage they prefer among a limited set of options. Under the traditional fee-for-service option, beneficiaries can go to most providers in the country. Medicare pays providers primarily based on prospective payment, an established fee schedule, or reasonable costs. About 84 percent of Medicare beneficiaries now opt for fee-for-service coverage.

Alternatively, beneficiaries can enroll in a Medicare+Choice plan. Generally, enrollees receive care from a network of providers. Most managed care plans receive a monthly, per-enrollee capitated payment that covers the cost of Part A and B services. The Administration will focus on expanding opportunities for beneficiaries to access a wider array of plans, including Preferred Provider Organizations and plans that offer a point of service benefit, allowing beneficiaries to receive certain services from non-network providers.

Spending and Enrollment

Federal spending on Medicare benefits will rise by an estimated average annual rate of 5.4 percent from 2002 to 2006, from \$226 billion to \$279 billion. Part A benefit outlays will grow by an estimated 23 percent over the period—from \$140 billion to \$172 billion, or an average of 5.3 percent a year.

Part B outlays will grow by an estimated 23 percent—from \$85 billion to \$106 billion, or an average of 5.7 percent a year. These figures cover net Federal spending on Medicare benefits, and do not include spending financed by beneficiaries' premium payments.

Medicare enrollment will grow slowly until 2011, then rapidly increase as the baby boom generation begins to reach age 65 in 2011. From 1995 to 2011, enrollment will grow at an estimated average annual rate of 1.5 percent, from 37.4 million enrollees in 1995 to 46.9 million in 2011. After 2011, average annual growth will grow at a faster rate, with enrollment reaching more than 69 million in 2025.

The Two Trust Funds and Solvency

Hospital Insurance (HI) Trust Fund: As noted earlier in this chapter, the HI Trust Fund is financed by a 2.9 percent payroll tax, split evenly between employers and employees. Since current benefits are paid by current workers, Medicare costs associated with the retirement of the baby boomers starting in 2010, will be borne by the relatively small number of people born after the baby boom. As a result, only 2.3 workers will be available to support each beneficiary in 2030—compared to today's four workers per beneficiary. The Medicare Trustees recently reported that the HI Trust Fund depletion date improved slightly from last year's report (from 2025 to 2029) but HI spending will begin to exceed tax receipts by 2016. In addition, the Medicare Trustees reported that the HI Trust Fund is in worse long-term financial shape than the Social Security Trust Fund. The President plans to work with Congress to develop a long-term solution to this financing challenge.

Supplementary Medical Insurance (SMI) Trust Fund: The SMI Trust Fund receives about 75 percent of its income from general Federal revenues and about 25 percent from beneficiary premiums. Unlike HI, the SMI Trust Fund is really a trust fund in name only; the law lets the SMI Trust Fund tap directly into general revenues to ensure its annual solvency.

Comprehensive Measure of Medicare Solvency: Currently, there is no comprehensive measure of Medicare's solvency that takes into account SMI finances, as well as HI. This seriously underestimates the magnitude of the Medicare financial problem. The Medicare Trustees acknowledged this disconnect in their 2001 Trustees report. They stated that: "Although this report focuses on the financial status of the HI Trust Fund, it is important to recognize the financial challenges facing the Medicare program as a whole and the need for integrated solutions."

As the Trustees report begins to show, on a combined basis Medicare spending will grow from 2.2 percent of GDP in 2000 to 4.5 percent in 2030 and 8.5 percent in 2075. Sources of dedicated Medicare financing will rise at a slower rate, from 1.8 percent of GDP in 2000, to 2.2 percent in 2030, and 2.5 percent in 2075. The gap in Medicare financing will therefore grow from 0.4 percent of GDP in 2000 to six percent of GDP in 2075. The Administration will work to establish a comprehensive measurement of solvency in order to assess the overall financial outlook of the Medicare program.

Previous Medicare Reform Legislation

The Balanced Budget Act (BBA) of 1997 improved Medicare's financial outlook temporarily, while the Balanced Budget Refinement Act (BBRA) of 1999 corrected some of the unintended consequences of the BBA. The Beneficiary Improvement and Protection Act (BIPA) of 2000 added preventive benefits health care benefits, reduced beneficiary cost sharing, while also reducing some provider payments. Despite this legislative activity, the Medicare program requires additional

reform to address its poor financial condition, and the inadequate benefits package, among other problems. The Administration will work with Congress to further modernize Medicare and integrate prescription drug coverage, while also strengthening the Medicare+Choice program.

Budget Implementation

Medicare Reform: Many improvements in Medicare's outdated structure are needed to increase the quality of care for seniors and the disabled, to streamline the burdensome and inflexible bureaucratic controls, and to improve the program's financing. The budget devotes \$153 billion over 10 years for Medicare modernization, including providing for a prescription drug benefit for all Medicare beneficiaries (see Table 13–2).

The President plans to reform Medicare based on the following principles:

- Medicare should be modernized, to provide better coverage options, streamlined regulations, and higher quality of care.
- Medicare should assure that all seniors have affordable access to prescription drug coverage, as part of a modernized Medicare program.
- Medicare should provide better options for protection against high out-of-pocket expenses, particularly for low-income seniors.
- Medicare should have greater overall financial security, including an accurate measure of the financial status of the program as a whole, without raising payroll tax rates.

Table 13–2. Immediate Helping Hand and Medicare Modernization
(Outlays in billions of dollars)

	Estimate											Total	
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2002–2006	2002–2011
Immediate Helping Hand and Medicare Modernization	3	11	13	15	13	13	13	16	17	20	24	64	153

Reforming the Health Care Financing Administration (HCFA): HCFA faces the formidable challenge of modernizing its administrative infrastructure, meeting pressing statutory deadlines for program changes from the BBA, the BBRA, the BIPA, and the Health Insurance Portability and Accountability Act, and perhaps most importantly, the need to be highly responsive to its customers. HCFA management reform is an Administration priority. HCFA will undertake a major effort to modernize and streamline its operations to more effectively manage current programs and implement new legislation. The Administration will also examine more fundamental change in HCFA's mission and structure as part of this effort.

In addition, HCFA will also work to protect the integrity of Medicare's payment systems without imposing burdensome new requirements on providers. Previous legislation authorizes mandatory Federal funds and greater authority to prevent inappropriate payments to fraudulent providers, and to seek out and prosecute providers who continue to defraud Medicare and other health care programs. In 2000, the error rate was 6.8 percent, or \$11.9 billion. The 2002 goal is to reduce the error rate to five percent.

Performance Plan: HCFA has developed a set of performance goals to measure its progress in ensuring that Medicare beneficiaries receive the highest quality health care.

HCFA's 2002 goals include:

- increasing the percentage of female Medicare beneficiaries who receive a mammogram once every two years from 45 percent in 1998 to 52 percent in 2002;
- decreasing the one-year mortality rate among Medicare beneficiaries hospitalized for heart attacks from 31.2 percent in 1995 to 27.4 percent in 2002;
- reducing the prevalence of pressure ulcers (bed sores) in nursing homes from 9.8 percent in 2000 to 9.5 percent in 2002. Absence of pressure ulcers are a good indicator of quality of care provided by nursing home; and
- increasing the percentage of Medicare beneficiaries age 65 and over receiving vaccinations for influenza from 59 percent in 1994 to 73 percent in 2002, and those receiving a lifetime pneumococcal vaccination from 25 percent in 1994 to 65 percent in 2002.